

■ Monthly Billing Audit Checklist

Review Every Month to Keep Your Revenue Cycle Healthy • Medical Billing

Why Do a Monthly Audit? A billing audit helps you find mistakes before they cost you money. It catches unpaid claims, coding errors, and denied claims early so you can fix them fast. Set aside time at the end of each month to go through this checklist completely.

Month / Year:		Auditor Name:		Date Completed:	
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SECTION 1 — Claims Submitted This Month

What To Check		Notes / Reminder
■	Total Claims Submitted Count Count how many claims were sent to insurance companies this month. Write the total number down.	<i>Compare to last month</i>
■	All Charges Entered and Posted Every patient visit has been entered into the billing system. No visits are missing from the records.	<i>Cross-check with schedule</i>
■	Claims Submitted Within Timely Filing Limits All claims were sent before the insurance company's deadline (usually 90 days to 1 year from service date).	<i>Check each payer's limit</i>
■	Electronic vs. Paper Claims Ratio Most claims should be sent electronically (faster and cheaper). Check if any claims are still being mailed.	<i>Aim for 95%+ electronic</i>
■	Clearinghouse Rejection Report Reviewed Check for any claims the clearinghouse (middle system) rejected before they even reached the insurance company.	<i>Fix and resubmit same day</i>

SECTION 2 — Payments & Posting

What To Check		Notes / Reminder
■	All Insurance Payments Posted Every payment received from insurance companies has been entered (posted) into the billing system correctly.	<i>Match EOBs to payments</i>
■	All Patient Payments Posted Copays, deductibles, and self-pay payments from patients are all recorded accurately.	<i>Match receipts to system</i>
■	Payment Amounts Match EOB The amount of money received matches exactly what the Explanation of Benefits (EOB) says should be paid.	<i>Flag any differences</i>
■	Contractual Adjustments Applied The discounts your practice agreed to with insurance companies have been properly written off — not left as open balances.	<i>Check adjustment codes</i>

■	Unapplied Credits Resolved Any credit balances (where a patient or insurance paid too much) have been reviewed and refunded or applied correctly.	Resolve within 30 days
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SECTION 3 — Denials & Rejections

What To Check		Notes / Reminder
■	Denial Rate Calculated Calculate: (Number of denied claims ÷ Total claims submitted) × 100. A healthy denial rate is under 5%.	Target: under 5%
■	Top 5 Denial Reasons Identified Find out the most common reasons claims are being denied this month (wrong code, missing info, eligibility, etc.).	Address root causes
■	All Denials Worked and Appealed Every denied claim has been reviewed and either appealed (if the denial was wrong) or corrected and resubmitted.	Appeal within payer deadline
■	Timely Filing Denials Reviewed Any claim denied because it was submitted too late has been reviewed to find out why it was late.	Update submission process
■	Duplicate Claim Denials Investigated Claims denied as duplicates have been checked to confirm whether they truly were duplicates or a billing error.	Avoid future duplicates

SECTION 4 — Accounts Receivable (AR) Review

What To Check		Notes / Reminder
■	AR Aging Report Pulled Run the Accounts Receivable aging report that shows how long each unpaid claim has been outstanding.	Run on last day of month
■	Claims Over 90 Days Reviewed Every claim that has been unpaid for more than 90 days is reviewed and actively followed up on.	Priority action needed
■	Claims Over 120 Days Escalated Claims unpaid over 120 days are escalated — consider sending to collections or writing off if uncollectable.	Discuss with manager
■	Days in AR Calculated Calculate average days in AR: (Total AR ÷ Average Daily Charges). A good benchmark is under 40 days.	Target: under 40 days
■	Patient Statements Sent Patients who owe a balance have received a statement or reminder this month.	Send by 5th of each month

SECTION 5 — Coding Accuracy Spot Check

What To Check	Notes / Reminder
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■	Random Chart Audit Performed Pull 10–20 random charts and check that the billing codes match exactly what was documented by the provider.	<i>Document findings</i>
■	ICD-10 Codes Are Specific Enough Diagnosis codes are at the most specific level possible — not using general or vague codes when a specific one exists.	<i>Use code lookup tools</i>
■	No Upcoding or Downcoding Found Make sure codes aren't being billed at a higher level than what was done (upcoding) or too low (downcoding).	<i>Both are compliance risks</i>
■	Modifiers Used Correctly Any billing modifiers (two-digit add-ons to codes) are used only when the documentation truly supports them.	<i>Review modifier policy</i>

MONTHLY SUMMARY			
Total Claims Submitted:	_____	Total Payments Received:	\$ _____
Total Denials:	_____	Denial Rate %:	_____ %
AR Over 90 Days:	\$ _____	Days in AR:	_____
Issues Found:			

Complete this audit every month • Keep records for 7 years • Share results with billing manager